Care Quality Commission

SHC Clemsfold Group Limited

Kingsmead Lodge

Inspection report

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Date of inspection visit:
12 September 2018
13 September 2018

Date of publication:
07 February 2019

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This comprehensive inspection took place on 12 and 13 September 2018 and was unannounced.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have been made. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and September 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find. Kingsmead Lodge is a care home that provides nursing and residential care.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Kingsmead Lodge provides nursing and personal care for up to 20 people who may have learning disabilities, physical disabilities and sensory impairments. Most people had complex mobility and communication needs. At the time of our inspection there were 14 people living at Kingsmead Lodge. People living at the service had their own bedroom and en-suite bathroom. The home had two areas 'west' and 'east' wing however operated as one home and people had access to all communal areas such as the activities room and dining areas.

There was no registered manager at the time of this inspection. The service is required by a condition of its registration to have a registered manager. A registered manager is a person who registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were told a new manager had been employed and was starting their role at the end of September 2018.

Kingsmead Lodge has not been operated and developed in line with all the values that underpin the Registering the Right Support and other best practice guidance. Kingsmead Lodge was designed, built and registered before this guidance was published. However, the provider has not developed or adapted Kingsmead Lodge in response to changes in best practice guidance. Had the provider applied to register Kingsmead Lodge today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs. People with learning disabilities using the service should be able to live as ordinary a life as any citizen.

At the last inspection in August 2017, the service was found to be in breach of legal requirements and was given a rating of 'Requires Improvement'. The provider wrote to us after the inspection to inform us the

actions they were taking. At this inspection we found that the quality and safety of care provided to people had deteriorated and we identified four breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.This was due to a failure to notify the Commission of authorised Deprivation Liberty Safeguards (DoLS) which the provider is required to do by law.

At the last inspection, we were concerned as medicines were managed unsafely. At this inspection, we remained concerned as we observed practices had failed to improve. This included how staff administered medicines to people.

Four people had a percutaneous endoscopic gastrostomy (PEG) or a percutaneous endoscopic jejunal (PEJ) feeding tubes fitted. Staff failed to implement infection control measures when supporting people with their medicines and enteral feeding systems. This included a failure to wash hands and/or wear gloves. One registered nurse had not received training in PEG/J yet supported people with this area of care.

We identified other gaps in training provided to staff. All people living at the home had a learning disability. Some people displayed behaviours which may challenge others yet not all staff had received specific training on how to manage such behaviours safely and effectively.

Activities and occupation were not consistently person-centred. One activity observed did not promote people's dignity. We made a recommendation to the provider to review this.

The provider had failed to utilise guidance from The Accessible Information Standard when supporting people to be involved with their own care. Care records did not consistently demonstrate people's health needs were being met. Opportunities had been missed to support people to communicate effectively.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had not ensured a delivery of consistent high care across the service. The provider had failed to ensure the necessary improvements had been made to the care provided since the last inspection.

The provider asked people and their relatives views on the care they received using various methods including satisfaction surveys. Relatives shared mixed views on the care their family members received. This included whether complaints were responded to in a timely manner. We made a recommendation to the provider to review how complaints were managed.

The environment is spacious throughout and adapted to meet the needs of people who use wheelchairs. The home was decorated with pictures and photographs of people living at the home. Environmental risks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing. Staff employed by the home underwent a safe recruitment process.

People were able to receive visits from their relatives and friends whenever they wished at the home and staff knew people well. Staff had attended safeguarding adults training and knew how to protect people from abuse.

There was enough food and drink available and offered to people throughout our inspection at mealtimes and also in-between. The menu offered flexibility to meet the needs of people and their specific dietary requirements. People had access to external health care professionals including GP's who visited the home weekly.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were aspects of unsafe care and treatment which had been highlighted to the provider in the months prior to our inspection by external agencies and in some instances, we found that suitable action had not been taken to respond to these known risks. Therefore, lessons had not be learnt to improve care practices.

Infection control measures were not practiced by all staff and we observed unsafe PEG management.

Some aspects of medicines were managed unsafely including the administration of medicines to people.

Staff had attended safeguarding adults training and knew how to protect people from abuse.

There were sufficient staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There were some gaps in training This included a lack of training to assist staff in managing behaviours which might challenge.

The provider did not work consistently in accordance with MCA legislation.

Pre-admission assessments regarding people's physical, mental health and social needs took place prior to them moving into Kingsmead Lodge.

People were supported to access health care professionals when needed.

People were supported to have sufficient to eat and drink and people's individual physical needs were met by the adaption of the premises.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed people's dignity was not always respected.

We also observed people received care from staff who were kind and caring.

Staff promoted people's rights to be independent and encouraged to be involved with their own care.

Is the service responsive?

Requires Improvement

The service wasn't consistently responsive.

Personalised care was not always delivered to people. Improvements were needed to the activities and occupation provided to people.

Information including care plans were not consistently in an accessible format to aid people's understanding.

People's complex communication needs were not always fully explored and supported.

We received mixed feedback from relatives regarding how complaints were managed. We made a recommendation to the provider to review this.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership was poor. The service did not have a registered manager. The provider had failed to put in place an effective and robust auditing system to identify, measure and improve the quality of the service delivered to people.

The provider had received support from specialists in health and social care. However, they had not implemented the suggested improvements, and risks to people's health, safety and welfare had not been sufficiently mitigated as a result of this support.

We found failings surrounding the governance of training, PEG management, medicines and infection control.

Care records were not always completed accurately. This

included inconsistencies in responding accurately to people's health conditions.

The provider had failed to implement learning from incidents. This impacted on people's safety.

Kingsmead Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 13 September 2018. The first day was unannounced and the inspection team consisted of three inspectors, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise included services for adults with a learning disability. The second day of inspection consisted of three inspectors and the same specialist advisor and a medicines inspectors. The specialist advisor had specialist clinical experience in supporting people with complex heath needs.

Prior to the inspection, we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with two people who lived at the home to gain their views of the care they received. We also spoke with six people's relatives, during and after the inspection, about their views of the care their family members received. Due to the nature of some people's complex needs, we were not always able to ask people direct questions about the care they received. To obtain these, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon over the course of the inspection.

During the inspection we spoke with the registered nurse, the deputy manager, the manager and the regional operation's director. We spoke with the physiotherapist and the physiotherapist assistant, who were also employed by the provider. In addition, we spoke separately with two care staff, one team leader, the chef and the activities coordinator.

During the inspection, we observed medicines being administered to people. We reviewed a range of records about people's care which included seven care plans. We also looked at three care staff records which included information about their training, support and recruitment records. We read audits, minutes of meetings with people and staff, policies and procedures, accident and incident reports, Medication Administration Records (MAR) and other documents relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At the last inspection in August 2017 the provider was in breach of a Regulations about safe care and treatment as medicines were not being managed safely. We found registered nurses failed to record accurately the times people received their prescribed medicines. We also found medicines were being administered to some people covertly without consideration given to the safety and effectiveness of doing so. Covert medicines means giving people their medicines without their knowledge. Because of this the Safe section was rated as Requires Improvement. After the inspection the provider told us the actions they were taking to improve how medicines were managed on behalf of people.

At this inspection, we found the safety of care offered to people had deteriorated further. Whilst we found people were administered their medicines covertly in accordance with best practice guidance and in people's best interests, we found other aspects of medicines management to be unsafe. The provider had a medicine policy in place. However, we found staff members did not always follow it. The National Institute for Health and Care Excellence (NICE) provides guidance to prompt the safe administration of medicines. It states, 'make the record only when the resident has taken their prescribed medicine. It also promotes, 'Complete the administration before moving onto the next resident'. We observed a registered nurse administer medicines to people. The registered nurse signed the Medication Administration Record (MAR) prior to administering their medicines to a person. The registered nurse was not vigilant in checking to see if the person had taken their oral medicines, before moving onto the next person. We also observed the registered nurse took two people's medicines at the same time in unlabelled pots. This meant there was a risk incorrect medicines could be given to people. We shared our observations with the management team.

Some people at the home were prescribed medicines to relieve symptoms such as heartburn, indigestion and pain to be given on a when required basis. We found some of these medicines were not in stock at the home. This meant there was a risk these medicines would not be given to people as prescribed, if needed. Also, written guidance was not in place for some of these medicines to help staff make the decision to administer medicines at the time. This meant people may not be given these medicines consistently or to meet their needs.

People living at Kingsmead Lodge had a learning disability, physical disabilities and some people had complex health needs. They were all fully reliant on staff to meet their needs. We found risks to people had been assessed however were not managed safely and consistently. For example, three people living at the home required enteral feeding and had a percutaneous endoscopic gastrostomy (PEG) feeding tubes fitted. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and throat. Another person had a percutaneous endoscopic jejunal (PEJ) feeding tube fitted. This meant their feeding tube was fitted directly into their small bowel. The regional operations director told us the provider used the principles of care from The Royal Marsden guidance when supporting people with enteral feeding. The guidance states, 'clean hands with bacterial soap and water or alcohol based hand gel. Put on gloves'.

We observed staff failed to practice safe infection control measures when supporting three out of the four people with the management of their PEG/PEJ. For example, we observed all three staff members failed to

wash their hands or wear gloves when supporting people with this aspect of care. When a person's meal or 'feed' is being disconnected, a disposable cap should be used to isolate the area of the feeding tube to ensure infection control risks to people are minimised. We observed two staff failed to use caps and instead wrapped feeding tubes in tissue. They were then placed in people's back packs which were positioned on the back of their wheelchairs. Staff observed told us they did not know if the back packs had been cleaned. This practice of using tissues instead of caps and placing the tube in back packs, placed the 'feed' at risk of bacterial feed contamination. Bacterial feed contamination can cause sepsis, pneumonia and on occasions urinary tract infections as well as stomach related problems. The risk of infection is further increased for a person with a PEJ as the route to the small bowel bypasses a person's stomach's natural protective barriers. At the time of this inspection, one person with a PEJ tube fitted was on a second course of antibiotics. An x-ray had confirmed they had a chest infection. Therefore, staff should have been extra vigilant and apply infection control measures with all aspects of their care. The deputy manager told us and records confirmed, that all staff had been trained in infection control however from the poor practices we observed we queried the effectiveness of the training received. We have discussed gaps in training further in the Effective section of this report.

On the first day of the inspection, we also observed a registered nurse support one person flushing their PEG with water. Flushing is a process whereby staff flush water through a person's feeding tube in between giving a person their nutrition, hydration and medicines. We observed that the flush was administered unsafely as it was faster and more rapid than is advised. Continuous rapid flushing can lead to health complications for a person including ulceration. The deputy manager told us staff had been recommended to do so by a health and social care professional, due to blockages of their tubes in the past. They later confirmed rapid flushing had been recommended for when the person was receiving their food, not when flushing water. However, their care plan advised staff to administer 'slow' amounts of their food. No guidance was located from the provider during and since the inspection to state this was an agreed care planning procedure on behalf of this person. Therefore, a potentially unsafe practice had been adopted which placed this person at risk from physical ill health. We fed back our observations to the management team.

We also identified gaps in guidance for staff when administering medicines for people with PEGs fitted. Instructions on people's MARs did not specify whether medicine's should be administered via their tube. This meant there was a risk medicines could be given in error orally to people who had a PEG.

Kingsmead Lodge staff team included five permanent registered nurses. There was one registered nurse on duty each shift. Shifts were run from 8am to 8pm and then from 8pm until 8am. From Monday to Friday the deputy manager, who was also a registered nurse was present. The deputy manager told us they used agency nurses on occasions but not regularly to support covering leave. We checked to see if all registered nurses who worked at the home had received training on subjects such as PEG and medicines management. We found registered nurses attended medicines training and their competencies to perform medicine tasks were assessed. We also found most agency and permanent registered nurses had attended PEG/J management training. However, we found one permanent registered nurse had not attended PEG/J management training yet they were supporting people with this aspect of care during both days of the inspection. We had also observed physiotherapy staff had not attended training in PEG/J management yet had been observed disconnecting tubes incorrectly. A relative of a person who had an enteral feeding tube fitted said, "I worry all the time about [named person] safety. They do not seem to be that well trained or up to date with what [named person] needs. They don't look after [named person's] personal care properly and I feel especially with [named person] feeding they are neglected because they keep making mistakes". Considering we had observed unsafe PEG management care during the inspection we brought this to the attention of the provider's management team so this training gap could be addressed.

At the time of this inspection, some people were prescribed thickeners. Thickening powders are added to foods and liquids to bring them to the right consistency /texture so they can be safely swallowed to provide nutrition and hydration to people. At this inspection, we found risks associated with a lack of specific guidance for people who used thickening powders. For example, thickening powder containers stated, 'use as directed' and offered a guide to how many scoops to make a fluid slightly thick to extremely thick. For example, one scoop meant a fluid would be 'slightly thick' and eight scoops 'extremely thick'. However, there was no specific guidance to ensure the correct number of scoops were used at the time for staff to refer to. A staff member told us, "We did have a list of people up on the wall. They (management) got rid of that as it had people's names on it. All we have is some guidance on the wall in the kitchen". We checked the guidance in the kitchen however this was for a thickening powder which was no longer prescribed to people living at Kingsmead Lodge. When asked how many scoops the member of staff used, they said, "You use your own judgment, you get used to what they have". We established a mixture of care staff, activities co-ordinators and registered nurses administered thickening powders. We were also told agency care staff worked at weekends at the home. Therefore, without specific guidance for staff to refer to, there was a high risk people would be given the incorrect amounts of thickening powders which placed them at risk of choking and significant harm.

We were also concerned about the storage of thickeners. Some were kept in locked cupboards and were not accessible. However, we also found in one dining area thickeners were stored in a cupboard which was unlocked and wheelchair height level. This meant they could have been accessed by people who lived at Kingsmead Lodge. In 2015 a patient safety alert was raised by NHS England to raise awareness of the need for proper storage and management of thickeners. This was due to a serious incident where a person, who lived in a different care home died following the accidental ingestion of a thickening powder which had been left within their reach. The thickening powder they swallowed caused an obstruction to their airways. We shared our concerns for people and their safety with regards to the management of thickening powders, including the storage, to the regional operation's director and the deputy manager. The deputy manager told us they were not aware they were being stored in this way.

Prior to this inspection, a safeguarding concern was raised when the wrong thickening powders were sent with two people when they attended a day service. Enquiries into why this had occurred established the thickening powders were stock which was no longer prescribed to the two people. We asked the deputy manager what lessons had been learnt since the safeguarding enquiry associated with the management of thickening powders. They told us the risk had been removed as any old stock of no longer prescribed thickening powders had been returned. However, during the inspection we found two containers of thickening powders which were no longer prescribed to people in the home. The lack of actions taken by the provider since the safeguarding concern had placed people at further risk from harm. Due to the risks we found to people's safety we shared our concerns with the local authority safeguarding team for their review. We also wrote to the provider to seek assurances about the actions they had taken since the inspection.

At this inspection we read the accident and incident file. Accidents and incidents had been recorded and reported by staff to the deputy manager who then shared the information with external agencies such as the local authority safeguarding team. They had also notified the CQC in line with legal requirements. When an incident did occur, it was also sent to the provider's quality team for their review. We were told this was to ensure whether there could be any shared learning could be taken from how a situation was managed by staff. However, we found another example whereby the provider had failed to take all the necessary action required. A month before the inspection a person suffered a fall due to locks not being secured on their shower trolley. The deputy manager told us they had spoken with the staff supporting the person and they had been shown how to ensure the locks were secured in the future. However, we were also told a training need was identified whilst the provider was investigating the concern. The deputy manager told us the

additional training had been requested yet dates had not been confirmed, therefore, staff a month after the incident had not completed the identified training. This meant all had not been done in a timely manner since the incident to ensure risks were mitigated on behalf of people.

One person was prescribed oxygen. An oxygen cylinder stored in their bedroom was not securely stored and a warning label was not displayed as per national guidance. This meant there was a risk someone could come to harm as the oxygen cylinder had been stored in an unsafe manner. For example, if the oxygen cylinder fell over it may cause an injury to a person.

The above evidence demonstrates that not all was reasonably done to mitigate risks to service users. There were failings to ensure all staff had the competence and skills to provide care safely. Medicines were managed unsafely. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager, who was in day to day management of the home, took some action to mitigate the risks to people. They told us they had ordered new caps to be kept in people's PEG back packs so tissue would no longer be used when tubes were disconnected. They also told us they spoke with staff regarding infection control measures. On day two of the inspection, we observed the same registered nurse provide PEG support to a person. They washed their hands and wore gloves in accordance with best practice guidance. We also noted the flushing process was at a much slower speed. The deputy manager told us the registered nurse would be attending the next PEG management training. However, no immediate dates were provided to the inspectors to provide the necessary assurances.

Prescribed topical creams such as skin barrier creams to prevent pressure wounds, were prescribed and applied when a person received their personal care. Support was provided from registered nurses to new care staff with the administration of topical creams. Body maps and associated guidance highlighted for care staff when, where and how much cream to apply to a person. Records were completed to demonstrate they had been applied as prescribed. Care staff were able to tell us how they applied topical creams safely and effectively and if they had any concerns they would highlight them to one of the registered nurses.

At the last inspection, we wrote about the negative impact a large use of agency staff was having on care provided to people. At this inspection, we found there was enough staff to respond to people's needs. People, their relatives and staff told us this had improved. Staff told us, and records confirmed there was a regular use of the same agency staff who were more familiar with people and their needs. One staff member told us that there had been periods which had been difficult due to high use of different agency staff. They said, "We are lucky we have agency staff that are familiar to the people that live here". The deputy manager told us they were in the process of recruiting more permanent staff to improve this further. The management team used a dependency tool to establish safe staffing levels. We observed that staff responded within a reasonable time to those who required assistance. In addition to care staff the provider employed activity staff, maintenance, domestic and kitchen staff. This meant care staff could focus on providing care to people and respond to people's needs.

We asked people and their relatives whether care provided was safe. One person said, "They keep me safe". Another said, "I am (safe) it is fine". A relative said, "They do keep [named person] safe and monitor well". Another relative said, "[Named person] is well looked after, they have never done anything to make us worry". Another relative said, "I've never worried and think they do an amazing job for everyone". However, another relative said, "They appear to get quite flummoxed if [named person] is a little unwell or off key some days and a bit panicky. [Named deputy] steps in and deals with the situation".

Staff were only able to start employment once the provider had made suitable recruitment checks. This included; two satisfactory reference checks with previous employers and a Disclosure and Barring Service (DBS) check. Staff record checks included validation PIN for all qualified nursing staff. The pin is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). This process ensured as far as possible, that staff were of good character and had the skills and experience to meet people's needs.

Staff demonstrated they understood the importance of protecting the people they supported and were knowledgeable about different types of abuse. One staff member said if they were concerned about a person, "Go straight to [named deputy manager]". They added, "If no action was taken I would come to you guys (CQC)".

Kingsmead Lodge had a clean and well-maintained environment. Over the two days of the inspection domestic staff ensured the home remained clean, free from offensive odours and tidy. A relative told us, "It has always been well kept when I have visited". Another relative said, "It is always clean".

We checked records relating to equipment, such as hoists and wheelchairs. Equipment and utilities were serviced in accordance with manufacturers' guidance to ensure they were safe to use. Gas and electrical safety was reviewed by contractors to ensure any risks were identified and addressed promptly. Records confirmed that maintenance staff attended when contacted by staff to repair damage, which ensured people were protected from environmental risks. Other service checks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing. Fire equipment such as emergency lighting, extinguishers and alarms were tested by the provider's maintenance engineer.

Requires Improvement

Is the service effective?

Our findings

At the last inspection, the provider was in breach of Regulations associated with a failure to ensure all staff had received appropriate levels of training to carry out their role. After the inspection, the provider wrote to us to inform us of the actions they were taking. At this inspection, we spoke with staff and checked training records. In addition to the gaps in training we have referred to in the Safe section of this report, we continued to remain concerned that not all necessary training had been attended by staff supporting people.

The provider had its own training academy. The training academy facilitated an extensive rolling training programme throughout each year. Some training sessions were face to face sessions, whilst other courses staff could achieve through an on-line process or with the use of a workbook. We found staff had attended, amongst other subjects, learning disability and epilepsy awareness training. We asked the deputy manager if there were any people living at the home who may display physical challenges to others, including staff, they answered no. However, care plans, incident records and staff informed us there were two people who lived at the home who on occasions may become physically aggressive towards staff. Challenging behaviour training is sometimes called Positive Behaviour Support (PBS) training. PBS training can provide staff with an opportunity to have an understanding of why a person may behave in a certain way. It also provides staff teams with an opportunity to develop step by step guidance and strategies to ensure incidents of aggression can be managed safely and effectively. We found nearly all permanent staff working at Kingsmead Lodge had not attended training to develop their skills and competencies to manage people who displayed behaviours that may become challenging. We read agency care staff training profiles. We found agency care staff had attended training in subjects which included safeguarding adults and moving and handling people. However, we also identified nine out of 10 agency care staff had not attended such training. Rotas confirmed agency care staff worked evenings and weekends.
This meant their support in the home would have been provided by registered nurses who had also not attended PBS training. The provider operated a management on call system. However, this would not replace support from staff who had been trained in this areas when an incident occurred in the home at the time.

In March 2018 the National Institute for Health and Care Excellence produced further best practice guidance on how to support adults with a learning disability and behaviour that challenges. It states amongst other items providers and staff should be, 'providing strategies and interventions to support communication'. The guidance also states all staff should attend PBS training. The lack of training attended about why a person with a learning disability might behave in a certain way impacted language used within some care records we read. Care plans and incident forms used insensitive language when describing how to manage a person and their behaviours. They alluded to the idea that people being supported were in control of what happened and were behaving in a certain way towards staff with intent or on purpose. There were also missed opportunities to explore how people communicated with staff which may have added to a person's frustrations. We have discussed missed opportunities associated with supporting all people to communicate effectively further in the Responsive domain.

The provider's website describes Kingsmead Lodge as a, 'specialist adult care home providing 20 places for people with learning and/or physical disabilities.' However, we found the lack of training attended in PBS meant there was a risk incidents of a challenging nature would not be managed consistently and with a positive outcome for people. We fed back our findings to the management team for their review. The deputy manager told us they were about to undertake some work with the local authority learning disability team surrounding PBS. They said each person assessed with this need would have their care plans reviewed and a PBS care plan would be introduced. However, at the time of this inspection this work had yet to be implemented and staff had yet to be trained.

A few weeks prior to this inspection the provider had made the decision to reduce the number of registered nurses on duty on a day shift from two to one registered nurse. The regional operations director told us this was due to not all people living at the home being funded for and needing nursing support. One staff member told us this had a negative impact on care provided to people as the registered nurses were always, "Rushing around". They also told us since the change in the amount of registered nurses available they and two other staff had to change a person's dressing surrounding their PEJ. It required regular dressing as the area tended to leak. Whilst the staff member described how they carried out this care safely they also told us they had been offered no formal training from the provider. They did tell us their competency to carry out the task had been assessed by the deputy manager who was a registered nurse. Considering the poor practice, we had observed during the inspection regarding PEG/J management we shared our concerns regarding gaps in training with the management team.

We spoke with two relatives after the inspection. They shared concerns about the competencies and skills of the staff team. One said, "I feel agency staff need to be trained better before starting a shift as everyone is different and has different needs". Another said, "They (staff) do not give me much confidence".

The above evidence showed that staff had not always received appropriate training to enable them to carry out their duties as they are employed to perform. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, staff told us they felt supported by the deputy manager and complimented the 'hands-on' approach they used. We found staff received training in a range of other areas, which the provider had assigned as mandatory and essential to the job role. This included emergency first aid, moving and handling, physical disabilities, fire safety, health and safety, food hygiene and safeguarding. Staff were assessed as competent in moving people safely prior to providing this support directly to people. They also received regular supervision and appraisals from their line manager and the opportunity to attend regular staff meetings. A system of supervision and appraisal is important in monitoring staff skills and knowledge.

New staff were provided with opportunities to shadow experienced staff members until they were competent to work independently. New staff were also required to complete the Care Certificate, covering 15 standards of health and social care topics as part of their induction into working in health and social care. To achieve this, candidates must prove that they have the ability and competence to carry out their job to the required standard. Staff were also encouraged to complete Health and Social Care Diplomas (HSCD). These are work based qualifications that are achieved through assessment and training. This ensured people received care from staff who had been provided the opportunities to gain the knowledge and skills they needed to carry out their roles and responsibilities.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked that the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found mental capacity assessments were completed on behalf of people. However, records and staff we spoke with failed to demonstrate whether all people or their representatives had been involved in the process in their best interests. For example, one person, who was assessed as lacking capacity had mental capacity assessments completed for areas such as activities and outings, bed rails and to give consent for the use of their own photograph. However, there were no records of how each decision was made in the person's best interest and if all relevant parties agreed options chosen were the least restrictive.

Nine DoLS had been authorised by the local authority. A further three had been applied for by the provider and were waiting an outcome. We spoke with the deputy manager about whether any DoLS had any conditions and if so, were they being met. The deputy manager was not aware of any conditions within authorised DoLS, yet we found, some DoLS had conditions. For example, one person had a condition about ensuring their care records were clear about what level of support a person received at night time. The condition was not reflected in their care plan. Their care plan stated their DoLS expired in August 2018. However, the DoLS authorisation we read stated it expired February 2019. We were unable to check whether the gap in knowledge and care planning had an impacted on the person. However, it is the provider's responsibility to ensure all staff are aware of and meeting conditions within authorised DoLS. At other locations of the provider, we had already identified this as a concern, that is, where conditions within DoLS were not recognised by those in day to day management of the home. This meant the communication across the provider was an area which required further improvement.

On occasions staff provided care and support without seeking consent from people. For example, a staff member failed to ask a person whether it was ok to wipe their mouth and carried out the task without interacting with them. We also observed a staff member moved a person in their wheelchair, without asking them if this was ok with them. The staff member came from behind the person so they would not have known what was happening to them. It is important people are provided with opportunities to give consent prior to care being delivered to them. We have discussed the providers failure to notify the Commission of authorised DoLS in the Well-led section of this report.

The provider had not ensured service users consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider carried out assessments regarding people's physical, mental health and social needs prior to them moving into Kingsmead Lodge. However, information was not always utilised in how risks were managed effectively and safely at the time of this inspection. We have discussed this further in the Safe section of this report. The initial assessment processes in place considered certain protected characteristics as defined under the Equality Act. For example, people's religion and disability. We asked the deputy manager and a team leader whether they had systems in place to support Lesbian, Gay, Bisexual and Transgender plus groups (LGBT+). They told us they were able to support people across a diverse range of needs and would not discriminate.

Communication between staff working at the home overall was effective. Daily handover meetings took

place at which staff could discuss people's care and support needs. Daily notes were recorded which described how people presented throughout each shift and how they had spent their time each day.

Efforts had been made by the provider to ensure the environment and adaptations of the premises met people's needs in relation to their physical disabilities. Some people living at the home were wheelchair users. Corridors and doorways were wide enough for people who used wheelchairs to move around the shared areas. Where required, bedrooms were equipped with an overhead tracking hoist to assist with safe moving and handling.

People were supported to have enough to eat, drink and maintain a balanced diet considering individual needs. We observed staff provided people with choices and responded to people if they changed their mind about what they wanted to eat. The food looked and smelt appetising. There were allocated kitchen staff employed to prepare meals for people. The chef demonstrated he knew about people's specialist diets. One person said, "It is nice (food) It fills me up. I eat in the dining room and the chef is very nice and I can choose". A relative said, "It is great and the chef involves everyone in choices".

However, we did note one person, who had difficulties with eating was seen by a dietician in August 2018. The person was prescribed a nutritional supplement. The dietician recommended liquid meals should be offered if main meal is 'not tolerated before offering nutritional supplement'. We observed the person being supported at lunch time. Staff brought a pureed meal to them on a plate which was covered with a plastic cover. The person would have not been able to see the meal as the plate cover was, 'misted over'. The staff member offered them a nutritional supplement and the pureed meal was not shown to the person or offered to them. We spoke to the staff member about this. They told us if they offered the meal the person would have become agitated. We fed this back to the management team as this practice was not in line with the person's guidance and could have a detrimental impact on the person's health condition.

People's healthcare needs were recorded in 'My hospital passport'; this is a document which details what healthcare staff need to know about a person's care and support needs should they be admitted to hospital. Care records documented the input people received from healthcare professionals. Mostly, people and their relatives confirmed they had access to health and medical professionals when they needed. One person said, "I tell them and they call (health appointments)". A relative said, "I'm kept informed of all [named person's] healthcare needs". GP's visited the home and any changes to people's health needs were discussed and any actions to support people carried out. However, not all relatives were happy with the communication with the staff team about health appointments. One relative said, "I have to stay on top of it all. I feel because they (family member) has such complex needs they forget about the everyday ones like opticians and dentist".

Requires Improvement

Is the service caring?

Our findings

At the last inspection in August 2017 we found caring approaches were used which respected people's privacy and dignity. At this inspection the provider did not take all measures to protect people from risks of harm. This included how people were supported with their PEG management and their medicines. Therefore, a culture of caring values was not always evident across the home. We elaborated on these concerns in more detail in other sections of this report.

On the first day of the inspection, we observed two group activity session's. On one table staff were supporting people with a board game with music playing in the background. On the floor a physiotherapist and physiotherapist assistant had positioned people on beanbags and mats. They provided sessions to people in groups of two in front of each other and other people and staff. People's heads were placed not facing other people and next to where staff used as a natural walk way through between the kitchen and front entrance. This meant people walked past their heads on the floor overlooking them. Kingsmead Lodge had a physiotherapy room and other areas of the home, including people's bedrooms which would have been more private. The physiotherapists were talking quietly to people while providing treatment, however the music and noise from the other group activity dominated. Therefore, the people receiving the treatments may not have been able to hear the physiotherapists and the direction they were giving. We asked the physiotherapists the reasons behind the decision to hold sessions in this way. They told us this was to create a more sociable session. They told us they used this approach regularly in the same room. We also asked the management team the rationale for such a decision. They told us they had not seen this before and could not provide an explanation. People involved in the session were not able to tell us whether they were comfortable and found this approach dignified. We recommend the provider reviews this practice to ensure it is people's and/or their representative's choice to being provided physiotherapy treatment in this way.

This inspection took place over two days and our other observations of staff's interaction with people were positive and people's privacy and dignity was respected and they were included in their own care. For example, we observed a staff member supporting a person to make themselves a cup of tea, the staff member was supportive and encouraged the person to be independent in making themselves a drink and supported them to make the drink safely. We also observed this person and staff member talking about which table they would like to sit at for lunch.

Staff respected the need to keep information confidential and spoke sensitively when supporting people with personal care. Staff sat down next to people when they needed to support them, for example, with their meal and/or drinks. This meant they were at the same eye level as the person which promoted the person's dignity. Staff routinely knocked on people's bedroom doors before entering. We also observed staff smiling and engaging with people, discussing people's relatives or other areas of interest with them.

People told us staff were kind and caring. One person said, "I like them they are kind". Another person said staff, "Look after me and help me live happily and do things". Staff explained they supported people to be involved in all aspects of their personal care as much as they were able. One staff member said they,

"Encouraged them to brush their own teeth and their own hair". They added that some people, "Make their own cup of tea". People were supported to wear their own choice of clothes, makeup and/or jewellery. A staff member told us, "The deputy manager told us when she first started in March 2018 she found the home to be, "Too clinical" and she had tried to make Kingsmead Lodge, "More homely". At the time of this inspection, communal areas had or were in the process of being painted. The deputy manager told us, "We had a residents meeting where the peach colour was chosen". Minutes to the resident meeting also discussed new tablecloths people had chosen of the same colour.

Resident meetings and care plan review meetings provided people and their relative's opportunities to discuss what was important to them and be involved in the care they received. One person said, "They (staff) know me very well and what I need". A relative told us, "We feel we have the privacy and time we need with [named person] and we are supported in this". The provider operated a flexible visiting policy, People's relatives told us they were able to visit family members when they wished.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the provider was in breach of Regulations associated with person-centred care. We found a lack of personalised activities and occupation were offered and some people were at risk of social isolation. After the inspection the provider wrote to us and told us the actions they were taking.

At this inspection, we found activities were taking place and people were able to access the community. However, whilst we found some improvements had been made to activities and opportunities for occupation, further work was required to ensure they were personalised for all people living at the home. This included people having options regarding which time and day of the week activities took place. For example, activity time tables were rigid and the same routine was carried out each week. For example, people went shopping at the same time each week. Whilst we appreciate people have a need for routine, this was based on the availability of the mini bus and driver rather than people's choices on a day to day basis. The activities coordinator told us activities could not be changed on the day at the request of a person as they would need to be planned. This meant there was a lack of flexibility available if a person changed their mind on what they wanted to do. Some people had more active schedules than others. For example, three people accessed local day services. However, the opportunities were not available for all people. All the relative's we spoke with told us the activities offered to people could be improved. One relative said, "More one to one time with activities and being outside would be lovely". Another relative said, "Activities and stimulation are a real problem and non-existent most weekends. It just isn't enough". A third relative said, "Activity in general needs to be addressed, it's so quiet and always the same one or two going out".

Kingsmead Lodge had a sensory garden with raised beds and access to lawn areas surrounding the building. We were told the sensory garden was used by people, however records showed this was not used routinely. During the inspection we observed the sensory garden was not used and people were not supported to access the outside space, despite the second day of the inspection being warm and sunny. This was a missed opportunity for people to gain fresh air and appreciate the surroundings of their own home.

The provider also needed to ensure people's needs were reflected within care plans to ensure they captured their needs accurately. For example, one person was described in their care plan as displaying behaviours which physically challenged staff and other people. We established they had displayed physically challenging behaviour to staff yet not to other people they lived with since they moved to the service. Therefore, this was not an accurate and current reflection of the person at the time of the inspection. We spoke to the management team about reviewing the wording as the information was historical and needed to be written accordingly.

The provider used a written format for care plans which was appropriate for some of the people living at the home but not all. The Accessible Information Standard (AIS) is a requirement of NHS and adult social care services to ensure that people with a disability or sensory loss are given information in a way they can understand. Whilst care plans referred to the AIS, there was a lack of assessment completed to show how information should be recorded or shared with the person in an accessible way that specifically met their communication needs. Reasonable adjustments had not always been made to ensure that people's

information needs had been identified or consistently met according to their needs. For example, some menu's were completed in small wording font and displayed on the wall above wheelchair eye level. The menu's printed for tables used the written word only. Pictorial images of food were not included.

People's understanding would have been gained in a more meaningful way if pictures and/or photos had been used or objects of reference. For example, we observed staff's interactions with a person who was finding it difficult to eat. There was no use of pictorial or sensory items at the time by staff to help assist the person to understand what was being offered to them. We were told another person used to use cards to answer questions. Staff told us and care records confirmed, they found it more difficult to speak now. We were told the cards included a 'yes' or 'no' option. Staff told us they were no longer used however we were not presented with any rational as to why they had stopped being used. A member of staff who had been working at the home for many years and knew the person and their communication needs very well, told us the person only responded to a few staff members who they, "trusted". They told us they had known the person when they were able to speak verbally. They said, "[Named person] still understands everything. [Named person] will try their best. I don't use the yes and no cards", However, new staff or agency care staff may not have known the person and their communication needs as well. If experienced staff showed new and agency care staff how to use the cards then this may have supported the person to respond and communicate their preferences when asked a question. This may have also encouraged the person to develop more effective relationships with other staff members and peers.

Some people were assessed as using Makaton signs. However, we found no sign language was encouraged and used by the staff team. We asked staff whether they thought the use of Makaton, a type of sign language, might benefit some people and their ability to communicate with others. One staff member said, "Nobody has done it (training in Makaton)". They described how it might assist one person living at the home. They said it might help, "When you are struggling to understand [named person]". We were told the deputy manager was about to attend Makaton training however at the time of this inspection the training had yet to take place. We fed back our findings to the management team at the end of the inspection for their review.

The above evidence demonstrates that the provider had failed to ensure that people received care or treatment that was personalised specifically for them. This is a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, we also observed people enjoying the group activities which were taking place at the time of the inspection. This included a visit from an external entertainer who sang and played the guitar. We were told the entertainer came every week and was very popular with people living at the home. We noted people were encouraged to join in by singing and using percussion instruments. People smiled and laughed during the session and created a happy lively atmosphere.

Complaints were considered and responded to. There was a complaints policy in place available for both people living at the home and their relatives. There was a clear log of all complaints and the actions taken by the management team. There were no formal complaints open at the time of our inspection. Relatives we spoke with provided mixed feedback on whether complaints were dealt with a timely manner. One relative told us, "I've never complained but have asked questions of them and it's always addressed and resolved very quickly". Another relative said, "Issues are dealt very quickly by [named deputy manager], she is very proactive. They are efficient and we feel listened to". However, after the inspection, two relatives shared frustrations about how complaints were managed. One relative said, "We feel the home has gone downhill in recent years and we do complain to the management. Sometimes its addressed immediately but more often we are always waiting for staff to call us back or to find a nurse to help us". Another relative shared, "I've made so many complaints to the home and their management. They make false promises". We

recommend the provider reviews how all complaints are responded to, to ensure people and their relatives are responded to in a timely manner and in line with the provider's complaints policies and procedures.

We found the staff team had responded to people's preferences with regards to how bedrooms were decorated. Bedrooms reflected the age, style and interests of the person. People were able to display all their personal items, such as posters of their favourite popular music artists and had choice over the colour of paint used on the walls. One person told us their bedroom had been painted purple as it was their favourite colour.

At the time of this inspection, there were no people receiving end of life care. However, procedures were in place with the GP so that people would receive a comfortable, dignified and pain free death. This included access to pressure relieving equipment and pain relief medicines. People and their relative's had been consulted about their wishes in the event of their death and this was recorded in their care plan.

Inadequate

Is the service well-led?

Our findings

At the last inspection in August 2017 we found there were systems to assess, monitor and improve the service but these were not being operated effectively. There were four breaches of Regulation and because of this the service was rated as Requires Improvement. Shortly after the inspection, the provider informed us the action they were taking to address this.

At this inspection, we found care had deteriorated and people were not being provided consistent safe care and treatment. This included a significant lack of infection control measures being applied which placed people at risk from harm. We fed back our concerns to the management team who offered limited assurances at the time of the inspection to ensure risks would be mitigated. However, due to the failure to identify and improve since the last inspection we were not confident systems and processes would be embedded and sustained to improve the quality and safety of care provided to people. We wrote to the provider's nominated individual after the inspection to highlight our concerns further. They informed us the concerns raised were being dealt with by the provider's quality team. However, no specific actions were shared with us to provide the necessary assurances that actions had been taken to ensure people received consistent safe care and treatment. We wrote again to the nominated individual on 7 October 2018 and told them we needed to know what actions they were taking to ensure all people received safe care and treatment. The nominated individual responded the next day and informed the Commission the actions they were taking to mitigate risks on behalf of people.

Since the last inspection, there had been a change within the management structure. There was no registered manager in position. The service had been supported by two different managers since February 2018, who had since left, one was now managing another service owned by the provider. The deputy manager, who had been in post since March 2018, had been in day to day management of the home since July 2018. They told us they had been supported by a registered manager from another registered location owned by the provider and the regional operations director. The provider had developed a new senior management team. The new senior management team were making checks on care delivered to people. This included quality auditors carrying out audits on the service which were complete with areas which needed improvements. However, the systems in place to check the quality and safety of care provided to people remained ineffective. They failed to highlight all the areas we identified on this inspection. For example, medicine audits took place. However, they failed to highlight the concerns we had about how medicines were being managed. This had also been a concern at the last inspection. This meant the necessary improvements had not been made to ensure the legal requirement was now met.

On the first day of the inspection we observed poor PEG/PEJ management by qualified health professionals who worked for the provider. The staff observed had not attended training where their skills and competencies had been assessed. The gaps within training had not been picked up when checks on care had been made by the provider. The lack of effective governance over training systems placed people at risk of receiving unsafe care and treatment. We were unable to assess how long unsafe practices had been used. Since May 2017 the provider had received significant support from the clinical commissioning group and from the local authority. This support was focussed on improving the service to ensure people received safe

care and treatment. This ongoing support included support in relation to concerns previously identified regarding the support people with enteral feeding tubes received. Despite this, we found the provider had not applied learning from the clinical commissioning group or the local authority to ensure people received safe care at Kingsmead Lodge.

Some care records failed to demonstrate all care was being provided to people as agreed within care planning. We discussed this with the management team. For example, one person was at a high risk of skin damage due to their skin integrity. Their care plan referred to them being re-positioned once at night time to mitigate the risk of damage to their skin. There was no specific re-positioning chart in place. We spoke with the regional operations director about this. They said, "There should be one, this is something we can put in place." Another person, was at risk of constipation. Their care plan referred the reader to the Bristol stool chart (BSC). This is a diagnostic tool designed to classify the form of the human faeces into categories. Staff completed a bowel chart on their behalf. Their bowel monitoring chart had been completed incorrectly. The entries made were not in relation to the BSC categories. Due to the lack of accurate records in place we queried how the nursing staff would be able to monitor effectively whether the person maybe experiencing constipation or not. This meant the correct action, such as administering medicines to relieve the constipation, may not be given. We spoke to the registered nurse and deputy manager about this for their review.

The provider had introduced the National Early Warning Score (NEWS), across different locations, since November 2017 and at Kingsmead Lodge. This is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. The NEWS will include a baseline for what a person's temperature, pulse rate and oxygen saturations should be and what actions registered nurses should take if physiological checks they take are outside of the baseline and a person's health deteriorates further. NEWS for people's care we checked at this inspection, had not always been completed. For example, the registered nurse told us NEWS was completed weekly on behalf of all people to record baseline levels. However, there were no records throughout June and July 2018 for one person yet completed for one week in August 2018. We also read that daily notes completed by registered nurses had not transferred into NEWS when the person experienced a fall in August 2018. Yet this would be the ideal time for it to be implemented. Another person's NEWS had not been completed since early August 2018. Different colours such as red, amber and green were used in NEWS charts to identify and warn a staff member where baseline readings were positioned to ensure the correct response could be given. The same person's NEWS was photocopied in black and white only. This meant a system that had been introduced to ensure staff made the correct decision when a person's health deteriorated had not been implemented correctly.

In October 2015, national guidelines were published in relation to supporting people living with a learning disability and/or autism, under 'Building the Right Support'. The guidelines talk about the support people need to enable them to live the lives they choose and that services should be more person-centred. The Commission published a policy in June 2017 regarding the new registration of services supporting people with these defined needs. Kingsmead Lodge, was registered prior to this guidance being published. Nevertheless, we would expect providers of existing services to develop plans and strategies on how they will provide, improve and enhance the lives of people they support, to enable them to live meaningful and fulfilling lives. We spoke with the deputy manager about their understanding of 'Registering the Right Support', the Commission's policy, but they were not aware of this guidance. The findings of our inspection reflect that people did not always receive the consistent care and support they needed and were entitled to, to ensure they received high quality, compassionate care. This included a lack of evidence that all people consistently received personalised activities as most were generic in nature and often aimed at the group rather than the individual person.

The provider had failed to put in place robust measures to drive quality and sustain improvements at the service. The concerns we identified and raised at this inspection were also identified at the last inspection and in other inspections at other locations owned by the provider. This had not encouraged the provider to ensure improvements to the quality and safety of care provided to all people living at Kingsmead Lodge had been made.

The above evidence shows that the systems or processes in place were not consistently effective. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to maintain an accurate and cotemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had legal responsibility to complete and send to the Commission statutory notifications. Notifications are changes, events or incidents that the service must inform us about. This included any authorisations in relation to Deprivation of Liberty Safeguards (DoLS) under the Mental Capacity Act 2005. Nine DoLS had been authorised by the local authority, but the provider had not notified to the Commission as required each time. The provider had only informed the CQC of one DoLS in the past 12 months. We were not provided with an explanation of this during the inspection and since.

The above evidence demonstrates that the provider had failed to notify the CQC of incidents which had occurred whilst services were being provided in the carrying on of a regulated activity or as a consequence of this. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We checked how the provider gained people's and when necessary, relative's views of the quality of care provided. People were provided opportunities at care planning reviews and at resident meetings to share their views. Relatives could speak with staff when they visited and surveys were sent out monthly from the provider's head office. Survey responses we read were all positive and demonstrated the staff team adopted an open-door policy which helped promote an inclusive atmosphere. The deputy manager was not the registered with the Commission. This meant they did not have the legal responsibility to meet the requirements of the Health and Social Care Act. However, they told us they were, "Doing their best at their level". All staff, people and their relative's complemented the deputy manager and the care and support they provided. One relative said, "We understand there has been problems with the management here but it has not affected us, we are happy with [named deputy manager] as the manager". Another relative said, "[Named deputy manager] is brilliant and really has been supportive, listens and works hard for us all. I cannot fault them and know her hands are often tied".

On the 1 November 2017 amendments to the Key Lines of Enquiry (KLOE) came into effect, with five new KLOE and amendments to others that all regulated services are inspected against. The deputy manager was aware of the changes and shared with us communications by the provider about how the amended KLOE would impact on location inspections.

The deputy manager told us they were committed to improving the service offered to people and the support provided to the staff team. They told us they were most proud of improving, "The atmosphere" and morale of the staff team. They spoke positively of the staff team. They said, "Here they do genuinely care. They (people) are like family to us. I would put my mum here".

The deputy manager told us they worked alongside other health and social care professionals and partner agencies. They told us they were keen for this to continue to benefit the people living at the home. The deputy manager told us the rapport with partner agencies, such as the local authorities safeguarding and commissioning teams had improved as they were open and transparent with them. They said they had,

"One vision for the home to improve". The regional operations director told us a new manager had been recruited and would be starting at the end of September 2018. They told us they would be applying to become the registered manager thereafter.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Personalised care was not consistently provided to all service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not consistently working in accordance with the MCA legislation.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were failings regarding how risks were mitigated on behalf of service users. This included PEG and medicines management.

The enforcement action we took:

Imposed provider level conditions see overall summary

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of robust and effective checks made on the quality and care provided to service users. This included a failure to improve since the last inspection.

The enforcement action we took:

Imposed provider level conditions see overall summary

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training had not been attended by staff in key subject areas. This included training to support staff to manage behaviours which may challenge others.

The enforcement action we took:

Imposed provider level conditions see overall summary